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ABSTRACT

One of the maladies of living that seems to be of endemic proportions in Western society is affective deficit, experienced as emptiness, lack of fulfillment, dissatisfaction with obvious success, or a sense of not being complete nor even of being okay. This paper establishes a case for the importance of recognizing and developing interventions for deficit states, particularly affective deficit, in clients and patients. Of the three categories of deficit states (cognitive, affective, and behavioral), affective deficit is the most difficult to circumscribe. Definition and description are given, most clearly in the experience of emptiness within a context of "Everything is going extremely well." Results from two studies are provided, one on obsessive-compulsive disordered subjects and one on individuals who had experienced dissolution of long term relationships. An overview of intervention strategy is given. It is concluded that there are sufficient explanations and data supportive of an area of affective deficit to warrant more empirical study. (Author/TS)

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Affective Deficit in Clients: The Role of the Therapist

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Abstract: A case is established for the importance of recognizing and developing interventions for deficit states in clients and patients. These deficit states are framed in three categories: cognitive deficit, affective deficit, and behavioral deficit. Of the three categories, affective deficit is the most difficult to circumscribe. Definition and description is given, most clearly in the experience of emptiness within a context of "Everything is going extremely well." Results from two studies are provided, one on obsessive-compulsive disordered subjects and one on individuals who had experienced dissolution of long term relationships. An overview of intervention strategy is given. It is concluded that there are sufficient explanations and data supportive of an area of affective deficit to warrant more empirical study.

Affective Deficit in Clients: The Role of the Therapist

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One of the maladies of living that seems to be of endemic proportions in Western society is affective deficit. This is experienced as emptiness, lack of fulfillment, dissatisfaction with obvious success, or a sense of not being complete nor even of being okay. It seems especially paradoxical when verbalized by people who have reached high levels of obvious success in socioeconomic pursuits, professional performance, and/or physical and social attractiveness. When the surprise suicide of a prominent person occurs, there often are signs of affective deficit; in fact, it is hard to find any other explanation. When a periodically depressed person or someone with obvious difficulties commits suicide, it is easier to explain his or her actions as escape from unpleasant conditions such as repeated failure; in many such cases it makes more sense to explain their action in terms of "what's not right" than in looking for what's wrong.

Some foundation of the deficit state model will be helpful before proceeding further with affective deficit.

Deficit States

"What's wrong with me?"

"I can't figure out what is keeping me from feeling okay."

"What am I doing wrong?"

Such are common utterances of clients, patients, friends, confidants, and they indicate the dominance of medical model mediated thinking. The vision of an invading organism that causes a disease state or creates a physiological overreaction is an easy frame for explaining problems. Even with the advent and popularity of holistic health, there remains a tendency to frame problems, discomfort, self-defeat, and/or unhappiness in terms of comission rather than omission. It would seem equally as probable that the following, different expressions, would lead to an accurate frame:

"What isn't right with me?"

"I can't figure out what I might do to enhance an okay feeling."

"What am I not doing right?"

One example of these dynamics is response to the conditions and feelings described as stress. Complaints of being overly stressed are rampant in our society. Stress-related maladies are becoming ever more apparent. The most frequent explanation is of the nature of, "I am doing

too much. There are too many demands on my time and energy." While such may be an accurate assessment of the situation, often there are confounding circumstances such as other people doing as much or more and not suffering similar conditions, and moderate reductions in activity resulting in little or no amelioration of symptoms. One explanation for the confounding information is that people have widely varying abilities to withstand stress or to carry demanding loads. Much has been made of personality types and their impact on tension diseases.

Another explanation, much less frequently encountered, is the existence of a deficit state. Rather than "I have too many drains on my energy," it may be that "I have too few sources for generating energy." Maybe people who are "filled" or fulfilled have a greater capacity to expend energy without suffering from stress maladies. Maybe emotional income dynamics are as important, if not moreso, than those of an emotional expenditure kind.

The kind of thought frame that includes both problems of commission and omission, surplus and deficit can be applied to many human conditions and performances in addition to stress-related ones. One model (Gerber, 1986) suggests categorizing individual's problems into those of thoughts and information (cognition), those of feelings or

emotions (affect), and those of actions (behavior). Each of those categories can be further divided into surplus and deficit states, resulting in six assessment categories: cognitive deficit, cognitive surplus, affective deficit, affective surplus, behavioral deficit and behavioral surplus. Logically, each different category has different characteristics and each will be, therefore, differentially responsive to treatment interventions. Simply, a cognitive surplus problem is treated best by a cognitive surplus technique.

Five of the six categories are explained rather easily. A cognitive deficit state is simply one of ignorance. A cognitive surplus state usually indicates irrational or conflicted thinking and corresponds to the focus of therapists who specialize in cognitive restructuring, such as Ellis (1969) and Beck, et. al. (1979). Behavioral surplus and deficit are represented in operant conditioning language as the presence of externally cued, habit responses that are undesirable or the absence of such habit response which would be self-enhancing. Affective surplus is manifested by two extremes of emotional expression: (1) frequent and volatile expression of feelings such as anger, self-pity, moroseness, artificially supported elation, or tenseness, and (2) absence of expression referred to as flat affect, usually indicative of the presence of intense emotions kept in

neurotic check--the lid tightly screwed on. Affective deficit requires a more complex definition.

Affective Deficit

This state is not marked by absence of emotions; rather, it indicates a vacancy of vital feelings of worth and of personal validation. Expressions such as "I feel so empty," and "My life is going well in every respect; how come I feel so incomplete or so dissatisfied?" indicate a deficit state. A theoretical referent for this condition is Maslow's need hierarchy (1954), specifically what he described as the middle section--need for love and belonging. These needs are usually fulfilled through position in an integrated, accepting, functional family wherein a person has a place simply by virtue of being born into that family unit. Unfortunately, many families are dysfunctional, providing an insufficient structure of valid belongingness, and teaching the propogation of the same dynamics into the second and third generation.

In Western society, this also occurs from an overreliance on achievement as the mark of success, i.e., personal value. It happens subtly and automatically when the parent or parent surrogate communicates "I like/love it/you when you clean your room/get good grades/ make winning touchdowns/win beauty awards, etc." In contrast, personal validation, the

antidote for affective deficit, occurs through expressions of love and acceptance even at times of disappointing failure, violation of parental hopes and expectations, and mediocre performance. Contingent validation is a self-esteem strategy which, according to Maslow, will work only if the prerequisite need for love and belonging is satisfied. This may explain why so many admirable, high achieving, successful people engage in serial marriages, struggle through disruptive mid-life transitions, and commit suicide. If world class achievement fails to produce happiness, if the American success dream and promise of happiness through success turns out to be a lie, then desperate options must be exercised. Affective deficit is a widespread condition, especially in highly educated populations. Their plight is further exacerbated by their practiced tendency to try to solve everything by thinking about it.

Information from two recent research projects will provide a look at this condition within populations of clients diagnosed with obsessive-compulsive disorder and within populations of people who have experienced unstable/unsuccessful relationships especially as compared to those with stable/successful ones. The samples in each study were small in number and the methods employed were a little cumbersome, both conditions necessary for the pioneering nature of the research. In each

study, the experimenter relied on recorded and transcribed information elicited through interviews based on indirect questions and pursuit of examples or vignettes. The subjects' reports of personal experience were analyzed for the existence and preponderance of statements judged to be evidence for affective deficit states or for the presence of personal validation.

Obsessive-Compulsive Disorder and Affective Deficit

The following are some exerpts from interviews with OCD clients. They are representative of statements indicative of problematic relationships with parents. Parents usually are the source of personal validation or of either contingency based relationships or dysfunctional patterns which result in affective deficit.

> My childhood with my parents was very abusive. My father was a tyrant. The dynamics were that he was abusive to me and my mother did not protect me. There were a lot of threats, daily emotional abuse; for example, my father telling me that I was shit and could do nothing right--no praise, always criticism for things I did and didn't do. Also there was daily threat of physical violence. There was also physical abuse; for example, if I got angry or cried, then I would be hit

or spanked with a stick. It was not ok for me to have any feelings. If I cried, I was punished. If I got angry I was punished.

Organized sports were quite stressful due to the fact that my father put so much pressure on me to perform well as an athlete. Yet even if I was on an allstar team, he still wasn't pleased.

I'm not clear how it all developed, but I have always had to be my mom's "therapist," so to speak. I've always had to be there for her emotionally, but she's never been there for me like that. In fact, in a twisted way I was the family therapist. Their feelings came before mine.

With my grandmother, I always felt loved for who I was. The trouble was that all through my public school period I didn't see her much because she lived so far away. She was probably the closest I had to someone giving me unconditional positive regard.

I always sensed I wasn't good enough. Nothing I did was right, even now, a subtle invalidation process. Recently, I was cooking and my mother was engaging in a constant subtle

belittling, "Why are you doing it that way? You're doing this wrong." This was the same in childhood--the belittling, telling me I wasn't doing things right. I never felt good enough.

My father was king of the household and required perfect manners at the table, or you could get thumped on the head.

Conclusions from the study of this population included a preponderance of statements reflecting consistent contingency relationships with parents (75% of all statements), onset of compulsive behavior in childhood, and the beginning of remission of symptoms following a validating relationship with a therapist.

Unstable/Unsuccessful Relationships and Affective Deficit

The following are examples of statements from individuals who have experienced the dissolution of lengthy relationships. Like those of the previously mentioned study, there are examples of contingency relationships in the formative years. In addition, there are statements which indicate an attempt on the part of the subject to get personal validation from the partner, an ineffective strategy because of the mutual give and take of such relationships.

I'm the black sheep of the family, me with all this education and a ridiculously high grade point average for God

only knows how many credits at this point. Everyone in my family is a doctor or if they're not, they have resumes that take an hour to read and they're driving BMW's and living next door to Jimmy Connor, you know?

My sister was always prettier, smarter, more sophisticated, a sharp dresser, witty as hell. She was a cheerleader, a model, valedictorian of her class, a beauty queen. How could I compete with that? I know my dad didn't realize what he was doing, but he'd say things like, "Why can't you be more like your sister?"

It was just impossible for me to believe anyone could love me for just being who I really was. In my family, the operative word was "pride." My parents could be proud of you, but you had to meet some pretty high standards.

I guess I was kind of a momma's boy, you know, 'cause she wanted me to be real active in the church, like the leader of the youth group and sing in the choir and all that, and I did--I did all that stuff.

It was like you knew if you did something wrong. She'd get real quiet and I think she used to go in her room and pray for

us, you know? Or she'd start crying, and that was worse, way worse.

I remember we used to all walk around with these guilty consciences. She couldn't stand us squabbling and she would have a fit if she'd known I was drinking and playing pool. Nobody raised their voices around Mom, not even Dad. I mean, we all learned to be ridiculously polite to each other, even when we felt like killing each other.

I worried Joe would get bored with me eventually, so I had to keep him interested.

I tried too hard to please him and forgot about myself.

I thought if I was successful, got hired on at [company], he would respect me more. We'd be more like equals.

Joe was actually a good man. He wasn't mean or malicious. He didn't realize how insecure I was, that every time he'd mention some little thing about his idea of the ideal woman, (the "goddess" he called her) that used to haunt him in his adolescent years, I would think he was disappointed in me, secretly finding fault that I wasn't somehow prettier, classier, bigger busted, you know [laughs]? And it wasn't all me. He did

compare me with other women sometimes. I just wish I would have told him to f... off, instead of trying to fit myself to some image that didn't fit me at all.

Conclusions from this study indicated a strong loading of contingency based relationship statements on the part of individuals experiencing unsuccessful/unstable relationships. The markedly contrasting statements made by individuals in relationships categorized as successful/stable indicated that either one or both partners had been personally validated. Similarly, there was moderate evidence to suggest that persons showing an affective deficit attempted to get validation from their partners with resultant dissatisfaction and increased dissonance in the relationship.

The major weaknesses in the two studies included limited samples and potential for researcher bias in eliciting information supportive of their hypotheses; nevertheless, the data was consistent and in the postulated direction. Also it was very consistent with the model of affective deficit.

Implications for Therapists

Based on considerable clinical experience and on the initial empirical research, deficit states exist, and particularly a condition

described as affective deficit. It is important for therapists to broaden their assessment frame to include, initially, deficit as well as surplus states (conditions in which the absence of some necessary or desired characteristic results in self-defeat or misery, in addition to maladaptative states resulting from the presence of largely externally imposed conditions or characteristics. Further it is necessary to differentiate among cognitive, affective, and behavioral types of concern, providing for a six-faceted model of maladjustment: cognitive surplus, cognitive deficit, affective surplus, affective deficit, behavioral surplus, and behavioral deficit. Such perceptual sorting of client circumstances enables therapists to select intervention strategies which address the dynamics unique to each type of problem situation. Such tailored interventions have a higher probability of successful and efficient results.

The relationship between cognitive restructuring and cognitive surplus conditions is apparent, as is that between operant conditioning procedures and both behavioral surplus and behavioral deficit states. Teaching procedures for cognitive deficit and emotional control/release techniques for affective surplus are multiple and generally known. Intervention strategies for affective deficit are not so apparent nor well known.

The description of affective deficit conditions includes a relationship based on contingency, overreliance on achievement as the mark of success, and absence of a sense of love and belonging. Ideally, these conditions are avoided in the normal development of a child in a functional family, one in which the strong, parent figures communicate over long periods of time the inherent value of the child. Children do not have to earn love and acceptance by meeting externally imposed standards; they often experience love and acceptance even when they behave unacceptably. They are loved simply because they exist in the family context. Their acceptance is automatic and comes before their behavior. In other words, these children have been personally validated by a parent figure.

Therapists generally encounter clients with affective deficit who were not afforded the conditions necessary for personal validation. These clients often behave as though they still are trying to please their dominant parent, in some cases long after the parent has died. Pointing this out to clients and coaching them in restructuring self-statements like, "I don't have to please my parents," is using a cognitive intervention for an affective concern. Sometimes it is useful in ameliorating symptoms; often it is not.

The "cure" for a deficit condition is to provide experience which fulfills the unmet need. If the deficit results from lack of a personally validating relationship, then providing such a relationship is an appropriate intervention. This suggests that therapists either become parent surrogates or help their clients to find some. Perhaps both dynamics are necessary with the therapist parenting the client until the client is strong enough either to engineer additional personally validating relationships or to internalize the validation and behave in self-empowering ways.

Clinical experience suggests that friends and spouses or mates are not able to provide personal validation because of the reciprocal nature of these relationships. The validator must be someone who is perceived to be more powerful than the client and beyond reciprocity. The validator must be someone whose opinion or judgment is both feared and accepted by the client. Through a period of relationship building in which the client permits himself or herself to be known thoroughly by the validator, the client becomes vulnerable to rejection by the powerful other person. Only when open to rejection can the client experience the acceptance that fills the affective deficit.

The dynamics of relationship therapies such as Rogers' person-centered approach (1951, 1958, 1959), which include unconditional positive regard and genuineness on the part of the therapist, generally provide personal validation if experienced long enough. Under conditions which prohibit or discourage several years of therapy, the traditional relationship therapy approach is contraindicated. At the same time, it is not realistic to treat a client with affective deficit in ten session episodes. Clinical experience indicates that the values inherent in the person-centered strategy can be managed effectively within an 18 month period. Instead of the often slow and rambling progession of non-directive dynamics, the client can be directed to make regular and frequent disclosure to the therapist of positive, neutral, and negative experiences. These can be incorporated into journaling or other homework assignments in addition to being processed in the therapeutic hour. Through the noncontingent acceptance of the client across the positive, neutral, and negative disclosures, the therapist personally validates the client. Once the affective deficit is fulfilled, the client is able increasingly to feel complete in therapy and to extend that condition to other relationships.

Conclusion

Considerable emphasis has been placed by human services professionals in identifying and remedying what is "wrong" with their clients or patients. Less emphasis has been given to deficit states, or to what is "not right" with clients or patients. Within the areas of potential deficit, referred to herein as cognitive deficit, affective defict, and behavioral deficit, the least examined and most difficult to define is the area of affective deficit. Definition and description have been provided along with clinical experience and the results of some studies which provide at least tentative support for the existence of such an area of concern and for its influence in at least two diverse populations. Supportive evidence from therapeutic endeavors by the authors is considerable and convincing, yet it is anecdotal in nature. More empirical demonstration of the existence of deficit states, particularly of affective deficit and of its import in therapy, is needed.

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